Request for Additional MFP Transition Services

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

MFP Field Personnel note: To obtain approval for additional MFP Transition Services, complete the following form. Services listed on this form must be needed by the participant and not initially identified during pre-discharge transition planning (i.e. the Pre-ITP/ISP) by the team. The MFP participant initials each additional service.

Participant First Name: **Participant Last Name**:

Participant Medicaid ID#: **Participant Date of Birth**:

Participant Address:

Participant City: **Zip**: **County**: **Waiver Name:**

Participant Phone Number: **Other Contact Name**: **Other Phone**:

Date of Post-ITP: **Date of Discharge:** **Date of Request**:

MFP TRANSITION SERVICE	RATIONALE (provide justification for why this additional MFP service is needed to support successful living in the community)	MFP PARTICIPANT INITIAL

MFP Field Personnel Name:

Region/Office: **Phone**: **Email**:

Field Personnel note: Send this completed form to the DCH/MFP Office via **File Transfer Protocol (FTP).** Contact the DCH/MFP Office regarding the dispensation of this request. If approved by DCH/MFP, submit completed reimbursement documentation (i.e. updated ITP, *Vendor Import File*, etc.) to Fiscal Intermediary via **FTP** and to DCH/MFP Office by **FTP**.

For DCH/MFP Office Use Only
Additional MFP Services Authorized: ☐ Yes ☐ No
Notes: